Concurrent Review Request Fax Form

PLEASE VERIFY ELIGIBILITY BEFORE SUBMITTING

Patient Information *(Please print or type)*

Patient Name		Admit Date
Gender Male ☐ Female ☐	Patient ID # or L&I #	Patient DOB
Subscriber Name *(If different from patient)*		ID #
FOR L&I ADMISSIONS ONLY:		
Description of Injury		Date of Injury

Facility and Physician/Practitioner Information *(Please print or type)*

Facility Name	NPI #
Facility Reviewer Name	Phone #
Physician/Practitioner Name	Phone #

Clinical Information *(Please print or type)*

Primary Diagnosis w/ ICD-9-CM® Code	CPT Code(s)
Number of Days Requested	Date Range of request
Chart Notes Attached? ☐ Yes ☐ No	Number of Pages
Current Treatment Plan	

Diagnostic Results	Lab Results
Discharge Plan or Other Issues	

Idaho Medicaid Fax .....(866) 539-0365